Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

June 29, 2016

Ms. Devida Deluca, Administrator
Living Well Residence
1200 North Avenue
Burlington, VT 05408-1004

Dear Ms. Deluca:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on May 24, 2016**.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _____	COMPLETED
	0543	B. WING _____	05/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WELL RESIDENCE	1200 NORTH AVENUE BURLINGTON, VT 05408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite re-licensing survey was conducted by the Division of Licensing and Protection on 5/24/16. The findings include the following:	R100		
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to reassess 1 of 4 sampled residents for a change in physical and mental condition (Resident #2), after a medical leave of absence. The findings include the following: Per medical record review, Resident #2 was admitted to the acute care hospital for heart surgery on 12/10/15. S/He returned to the facility on 12/23/15, 13 days post surgery. Per interview with the Registered Nurse (RN), Resident #2 had increased nursing needs on return. Changes include, but not limited to behaviors, total dependence on staff for transfer from one location to another, pain management and support with activities of daily living. A reassessment was completed by the RN on 2/25/16 some 50 days after Resident #2 returned to the facility. RN confirms that the resident assessment was untimely.	R136	Please see attached plans of correction.	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeanette O'Connor PhD, MS, MN Director of Wellness, Home Nurse		6/20/2016

STATE FORM 6899 4Y5L11 If continuation sheet 1 of 15

R136-R302 POC's accepted 6/29/16 MBertrand RN/PMC

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R161 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the manager of the home failed to assure that staff administering multiple eye drops to 1 applicable resident, had training and/or specific instructions for administering multiple eye drops at the same time (Resident #4). Findings include: Per observation on 5/24/10 at 8:57 AM, Med Tech #1 instilled 3 different eye drops in Resident #4's eyes: Artificial tears (a dry eye lubricant) 1 drop in each eye; Brimonidine Tartrate 0.15% (glaucoma medication) 1 drop in each eye; and Dorzolamide HCL 2% (glaucoma medication) 1 drop in each eye. The manufacturers prescribing information for both Dorzolamide HCL and Brimonidine Tartrate state that if more than 1 topical ophthalmic drug is being administered, the drugs should be administered at least 5 minutes apart from any other eye drop. Following the eye drop instillation, Med Tech #1 confirmed that s/he did not wait 5 minutes between administering each of the 3 different eye drops. At approximately 12 noon, the House Registered Nurse confirmed that instructions for administering multiple eye drop medications were not specified on Resident #4's Medication	R161		

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R161	Continued From page 2 Administration Record (MAR) and that the Med Tech had not followed the proper procedure in their administration.	R161		
R165 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions. This REQUIREMENT is not met as evidenced by: Based on employee file review and interviews with the Registered Nurse (RN) and Manager, the facility failed to monitor and evaluate 2 of 4 designated medication technicians on their performance in carrying out medication assistance/administration and blood pressure reading. The findings include the following:	R165		

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R165	Continued From page 3 1. Per review of 2 employee files, evidence could not be located demonstrating that both employees have had any further evaluation or monitoring for medication administration since the initial exam/evaluation. They are as follows: Employee #5 medication administration exam was completed on 4/10/15 and employee #6 medication exam could not be located. Per interview with both the Manager and the RN, confirmation was made that there is no formal process or annual review for the medication technicians after the have completed the initial training. Confirmation was also made that the test for employee #6 was taken some 2 years ago and can't be located. 2. Per observation of Employee #1 who had been instructed to conduct a blood pressure reading prior to the administration of Metoprolol (medication used to lower blood pressure), was witnessed applying the blood pressure cuff to the forearm of the resident. The diagram on the cuff indicated that the apparatus was to be applied to the upper arm above the elbow. When this was brought to the attention of the employee s/he responded that she was unaware of the diagram and the cuff was too small for the resident. Blood pressure reading with the cuff applied to the forearm registered a reading of 107/79 and the reading with the proper application of the cuff above the elbow registers at 143/106. Per interview with the Registered Nurse and the Manger both confirm that they were unaware that the blood pressure cuff did not fit the resident nor were they aware of the inappropriate application of the cuff.	R165		

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R165	Continued From page 4 (see 179)	R165		
R179 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and employee file review, the facility failed to ensure that 2 of 5 randomly sampled employees, have met the requirement of 12 hours of training annually for each staff member providing direct care to the	R179		

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R179	Continued From page 5 residents nor have they met the topic requirements. The findings include the following: 1. Review of the employee files, revealed that annual training has not been completed to include mandatory topics and mandated hours. Documentation evidences the following: Employee #4 to date, has a total of 4 hours of training from anniversary date of 3/10/15. Employee #5 to date, has a total of 4 hours of training from anniversary date of 2/2/15. Both employees have had education in the areas of Emergency Response, Respectful Communication, General Care and Supervision of Residents and Dementia training. Per interview with the manager, confirmation is made on 5/24/16 that the above information is accurate and that the Patient Care Attendants (PCA) have not met the annual mandatory requirements of 12 hours nor have they met the topic requirements as identified. 2. Per observation of Employee #1 who had been instructed to conduct a blood pressure reading prior to the administration of Metoprolol (medication used to lower blood pressure), was witnessed applying the blood pressure cuff to the forearm of the resident. The diagram on the cuff indicated that the apparatus was to be applied to the upper arm above the elbow. When this was brought to the attention of the employee s/he responded that she was unaware of the diagram and the cuff was too small for the resident. Blood pressure reading with the cuff applied to the forearm registered a reading of 107/79 and the reading with the proper application of the cuff above the elbow registers at 143/106. Per interview with the Registered Nurse and the	R179		

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R179	Continued From page 6 Manger both confirm that they were unaware that the blood pressure cuff did not fit the resident nor were they aware of the inappropriate application of the cuff. Employee #1 has completed 4 hours of education for the 2015-2016 year, however date of hire was 9/10/15. (See 165)	R179		
R181 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to complete an internal review for 1	R181		

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R181	Continued From page 7 of 5 employees who were identified to have a positive criminal background check at the time of hire. Findings include the following: Per review of personnel records for Employee #1, who is employed by the facility as a Patient Care Attendant and who has direct contact with residents, has felony findings on the criminal background review conducted on 9/11/15. There was no evidence of an internal investigation to determine if the staff member poses a risk to residents based on the specific charges obtained from the criminal review. Per interview with the facility Manager, confirmation was made that s/he was unaware that the previous manager had not investigated the charge or the effects the charge could have on the residents of the home. As a result, Employee #1's personnel file has no evidence that the facility has conducted an internal review to determine if the positive background check could place the vulnerable adults of this home at risk.	R181		
R188 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(2) A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident	R188		

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R188	Continued From page 8 objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that documentation regarding allergies was complete and accurate for 1 of 4 residents (Resident #4) and failed to ensure that 1 of 4 medical records contained a recent photograph for Resident #1. Findings include the following: 1. Per record review, Resident #4 was identified as having the following allergies on his/her physician orders: bees, shellfish, PCN (penicillin), Sulfa, Streptomycin and Ibuprofen. Per review of the resident's current Care Plan (dated 5/4/15), the resident was listed as having allergies to shellfish, strawberries, Fosomax, ASA (aspirin), codeine (pain medication), penicillin, Streptomycin and Sulfa Drugs. At Resident #4's last medical visit on 9/14/15, his/her primary care provider listed the resident as having allergies to shellfish, penicillin, streptomycin, sulfamethoxazole and Ibuprofen. On 4/24/16, Resident #4 was seen in the ED (Emergency Department) and administered Aspirin 162 mg chewable tablet. On 5/24/16 at 4:24 PM, the Director of Wellness/House Nurse confirmed the allergy lists for Resident #4 were not consistent in his/her medical record; Resident #4 received a medication (ASA) in the ED for which s/he is listed as having an allergy; and that there was no evidence that the home had determined which allergies were active/accurate for the resident.	R188		

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R188	Continued From page 9 2. Per review of the medical record (to include electronic and paper documents) for Resident #1, failed to include any photograph that would identify the resident. Per interview with the Registered Nurse, a photograph could not be located in the medical record.	R188		
R251 SS=E	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.a All food and drink shall be stored so as to protect from dust, insects, rodents, overhead leakage, unnecessary handling and all other sources of contamination. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store and protect all food and drink from dust, insects, rodents, unnecessary handling and all other sources of contamination. The findings include the following: Per observation/inspection of the kitchen storage cabinet and the refrigerator in the presence of the facility manager, the following was identified: 1. Multiple bags (partially used) of sugar and rice unsealed and not dated as to when the items were put in use. 2. The bottom of the dry storage cabinet had loose brown/black dried seeds/flecks of an unknown source on the bottom shelf. 3. The counter top in the kitchen had 3 loaves of bread partially used unsealed.	R251		

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R251	Continued From page 10 4. The kitchen refrigerator had multiple partially used plastic bags of grated cheese open and not dated as to when the items were put in use. 5. 2 Partially used plastic bags containing (1) deli roast beef and (1) deli ham dated to be used/sold by 5/17/16 nor were they dated as to when the cold cuts were put in use. 6. Multiple used jars of mayonnaise, minced/chopped garlic, pickles and condiments with no dates as to when these food items were put into use. Per interview with the facility Manger, confirmation was made that the above listed items were not stored properly in order to avoid various sources of contamination. S/He also confirmed that items put into use are to be dated and used for three days, then discarded.	R251		
R257 SS=E	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.g Doors, windows and other openings to the outdoors shall be screened against insects, as required by seasonal conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the residential care home failed to ensure that doors to the outside were screened against insects as required by seasonal conditions. Findings include: Per observation on 5/24/16 beginning at 7:45 AM, the door to the kitchen was observed to be wide open to the outside and without a screen. During a home tour beginning at 10:02 AM, the entrance	R257		

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R257	Continued From page 11 door on the living room side of the building was also open and without a screen. When the basement (accessed by stairs from the kitchen) was toured, a live bumble bee was observed. On 5/24/16 at 10:21 AM, the facility manager confirmed that the two entrance doors had been wide open and there was no screen doors in use; s/he also confirmed that Resident #4 (who resides on the first floor) has a bee allergy.	R257		
R266 SS=E	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the home failed to provide and maintain a safe, functional, sanitary, homelike and comfortable environment. Findings include: During a tour of the facility with the home's manager on 5/24/16 beginning at 10:00 AM, the following observations were made: 1. Floor vents on the first and second floors were soiled with dust and debris. 2. The plastic cover for the light fixture in the second floor bathroom was cracked and missing pieces, exposing sharp edges. 3. The alarm on the exit door in the upstairs bathroom was not functioning. 4. The light fixture over the stairway near the living room was heavily soiled with dust and	R266		

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R266	Continued From page 12 debris. 5. The linoleum flooring in the 1st floor bathroom (to the left of the toilet) was torn and lifted up, creating a trip hazard. 6. The cushions on Resident #1's electric wheelchair were heavily soiled with dark stains and the seat cushion had multiple tears. 7. Window panes on the storm door (off the living room) were cracked and loose. The above observations were confirmed with the home manager at the time of the tour.	R266		
R291 SS=E	IX. PHYSICAL PLANT 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure that the temperature of hot water in resident areas did not exceed 120 degrees Fahrenheit (F). Findings include: Per review of facility temperature logs from 4/7/16-5/23/16, the water temperature in the first floor bathroom sink (used by residents) exceeded 120 degrees (F) for 15 of the 18 days that the temperature was recorded; the high temperatures ranged from 122-127 degrees (F). The temperature in the kitchen sink (which is accessible to residents) exceeded 120 degrees (F) for 17 of 18 recorded temperatures in the same period; the elevated temperatures ranged from 122-127 degrees (F).	R291		

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R291	Continued From page 13 On 5/24/16 at 10:08 AM, the water in the first floor bathroom sink tested 128 degrees (F) and the water in the kitchen sink was 125 degrees (F). The home manager confirmed the above findings at the time of the environmental tour.	R291		
R302 SS=C	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview the facility failed to conduct any fire drills during the over night shift for the 2015-2016 year. Fire drills shall rotate times of the drills among morning, afternoon, evening and night shifts. The findings include the following: During review of the home's written records with the facility manger, confirmation was made that the 2015-2016 year does not evidence any drills were during the over night shift.	R302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0543	A. BUILDING: _____ B. WING _____	05/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WELL RESIDENCE	1200 NORTH AVENUE BURLINGTON, VT 05408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

Living Well Residence; Plan of Correction: Survey dated 05/24/2016

Corrections:

RESIDENT CARE AND HOME SERVICES

V. 5.7 Assessment:

ACTION:

- Electronic calendar and tracking system implemented to trigger notification of annual and re-assessment based on resident due date and change in condition.

MEASURES FOR SYSTEMIC CHANGES:

- Electronic tracking system is being set up that will automatically trigger assessments and re-assessments based on key criteria which will trigger an alert

HOW MONITORED:

- In electronic system, monthly reports will be pulled to review assessments due dates and completion

DATES IMPLEMENTED: Completed 06/20/2016

v. 5.10 MEDICATION MANAGEMENT: (Administration process and Training)

ACTION:

- Med techs will receive review of medication administration procedures for all avenues of medication administration including appropriate eye drop administration. This review will occur immediately and annually
- Med techs will receive review of where to locate specific details for each medication within the electronic medication system (QuickMAR).
- Pharmacy will be requested to include specific administration procedures for eye drops on all labels and to include this detail in administration instructions
- Med techs and staff will receive immediate and annual training in appropriate techniques for measuring, monitoring, and reporting resident vital signs

MEASURES FOR SYSTEMIC CHANGES:

- Med techs will receive review of medication administration procedures for all avenues of medication administration including appropriate eye drop administration. This review will occur immediately and annually

- Pharmacy will be requested to include specific administration procedures for eye drops on all labels and to include this detail in administration instructions
- Spot check observations will occur periodically throughout the year to assess and document appropriate medication administration practices
- Formalized annual review and observation of medication administration practices will be conducted immediately and around the time of each med tech's annual review
- Formalized annual review and observation of measuring, monitoring, and reporting resident vital signs.

HOW MONITORED:

- Medication administration practices will be monitored through spot check observations periodically throughout the year and at each annual review.
- Obtaining vital signs will be monitored through spot check observations periodically throughout the year and at each annual review.

DATES IMPLEMENTED: Completed by 06/30/2016 for immediate training and review of all med technician's technique and measuring of vital signs.

V. 5.11 Staff Services (Inservice & Training)

ACTION:

- The inservices that were scheduled and conducted were reviewed; and those additional trainings that were conducted, were submitted to the state surveyors.
- Mandatory topics that were deficient in training were identified and prepared; and were made available for immediate training and review with care giving staff.
- Staff will be required to review and sign off on state regulations annually

MEASURES FOR SYSTEMIC CHANGES:

- An annual calendar for trainings including all mandatory training will be developed and tracked electronically all year
- Set of inservice materials covering the mandatory trainings will be prepared and made available at all times for any caregiver needing to review specific mandatory topic
- Training will be formalized to specific subset of topics and tasks

HOW MONITORED:

- Quarterly review of records for staff will be conducted to identify training needs

- Electronic tracking system will be utilized to document and track all mandatory and additional trainings

DATES IMPLEMENTED: Completed by 06/30/2016 for immediate training

V. 5.11 STAFF SERVICES (Background Checks)

ACTION:

- Background checks must be returned prior to hire date
- Background check findings will be reviewed and any positive finding will be thoroughly investigated, followed by a decision for hire that will not endanger resident's wellbeing. All decisions will be made prior to hire date and will be documented in detail and placed within the potential employee's HR file.

MEASURES FOR SYSTEMIC CHANGES:

- Background checks must be returned prior to hire date
- Background check findings will be reviewed and any positive finding will be thoroughly investigated, followed by a decision for hire that will not endanger resident's wellbeing. All decisions will be made prior to hire date and will be documented in detail and placed within the potential employee's HR file.

HOW MONITORED:

- The House Manager will review new hire documents within a month and record review of this data. A summary checklist of this data will then be sent to HR manager documenting that all new hire requirements have been met.

DATES IMPLEMENTED: Completed by 06/30/2016

V. 5.12B RESIDENT CARE AND HOME SERVICES (ALLERGIES & RESIDENT PHOTOGRAPH)

ACTION:

- Record review of all medical records including paper and electronic are being conducted to verify discrepancies between the paper and new electronic medical records.
- Any medical record discrepancies found will be clarified with the primary provider and corrected in medical documents.
- In regards to resident #4 in question, medical documents are inconsistent for possible allergy, and request for accuracy and clarification of her allergies is pending.

- Record review of medical records, including photograph for resident #1 was completed and added to the medical record (electronic and paper).

MEASURES FOR SYSTEMIC CHANGES:

- Medical record review for thoroughness and accuracy in medical records will be reviewed upon admission, upon return from any overnight hospitalization, and upon annual review with primary provider

HOW MONITORED:

- Medical record review for thoroughness and accuracy in medical records will be reviewed upon admission, upon return from any overnight hospitalization, and upon annual review with primary provider

DATES IMPLEMENTED: Completed by 06/30/2016

7.3 NUTRITION AND FOOD SERVICES

7.3a Food Storage

ACTION:

- Clear glass jars and labels were purchased.
- All items that are edible and put into use have a "put in use" date on the label of the container
- All edibles are marked by items within the container
- All shelving in the storage shelf was cleaned
- Bread was labelled and sealed for date "put in use"
- Grated cheese was labelled and sealed for date "put in use"
- All meats taken out of the freezer are labelled and sealed for date "put in use"
- All condiments items in the refrigerator are labelled and sealed for date "put in use"
- Policy will be written to outline the process for ensuring food safety through storage and labeling.

MEASURES FOR SYSTEMIC CHANGES:

- Night shift staff will review refrigerator contents to check labelling of stored foods for safe consumption; including discarding foods that are out of date (greater than 3 days of age).

- The Chef and House Manager will meet weekly to review that the process for safe food handling is being conducted according to the policy guidelines and state regulations.

HOW MONITORED:

- The Chef and House Manager will conduct ongoing review that the process for safe food handling is being conducted according to the policy guidelines and state regulations.

DATES IMPLEMENTED: Completed by 06/30/2016

7.3 NUTRITION AND FOOD SERVICES

7.3 g Doors

ACTION:

- Screen placed on entrance door to the living room, and kitchen door will remain closed without a screen present

MEASURES FOR SYSTEMIC CHANGES:

- Annual calendar created with House Manager and Maintenance Manager to place screens on all windows and doors by May 1st.

MONITOR:

- Will be monitored by the House Manager prior to May 1st to ensure screen placement

Date Completed: Screen for living room placed 6/17/2016.

9.1 PHYSICAL PLANT

9.1a Environment

- Floors vents were cleaned
- Plastic cover on light fixture will be replaced with bathroom renovations
- Alarm on upstairs exit door was turned back on after Fire Marshall inspection
- Light fixture will be cleaned
- Linoleum in corner of first floor bathroom was secured with fixative agent, and flooring will be replaced with bathroom renovations
- Cushion on resident #1 chair was resident preference, and resident has declined replacement of cushion or covering

- Window pane on storm door is being repaired

MEASURES FOR SYSTEMIC CHANGES:

- Staff meeting held to review state regulations for the facility environment, and to address survey results regarding the physical plant
- Staff on different shifts are assigned additional cleaning and monitoring of the physical plant

MONITOR:

- House Manager will conduct ongoing monitoring for environmental condition of the facility

DATE COMPLETED: Screen for living room placed 6/17/2016; some repairs with bathroom renovations.

9.1 PHYSICAL PLANT

9.6 Plumbing (Hot Water Temps)

ACTION:

- Staff checking water temperatures daily
- Staff trained on reporting temperatures consistently over 120 degrees
- Staff member trained to turn water temperature down if temp is consistently over 120 (more than 3 days in a row, or 3 days in a week).

MEASURES FOR SYSTEMIC CHANGES:

- Staff member identified as the point person for monitoring and addressing changes to
- Staff on different shifts are assigned additional cleaning and monitoring of the physical plant

MONITOR:

- House manager will conduct ongoing monitoring

9.11 DISASTER AND EMERGENCY PREPAREDNESS

9.11c (Fire Drills)

ACTION:

- Fire drill data located and sent to surveyors, data outlines fire drills were conducted on all shifts.
- Overnight fire drill scheduled

MEASURES FOR SYSTEMIC CHANGES:

- House Manager and Maintenance Manager will schedule fire drills on all shifts and will document in Fire Safety Manual
- House Manager will conduct ongoing monitoring to ensure that fire drills are conducted on each shift and meet state regulations

MONITOR:

- House Manager will conduct ongoing monitoring to ensure that fire drills are conducted on each shift and meet state regulations